

**FILED** MAR 20 1946  
318

Primary Registration District No. **1003**

Registrar's No. **2433**

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Lutheran Convalescent Home 4359 Taft  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ 17 days  
(Specify whether

In this community \_\_\_\_\_ Life \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town Clayton  
(If outside city or town limits, write "RURAL")

(d) Street No. 6434 Cecil Ave.  
(If rural, give location) NR

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Helen L. Leguay

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F. / 5. Color or race W. / 6. (a) Single, widowed, married, divorced, Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Unknown  
(Month) (Day) (Year)

8. AGE: about ~~years~~ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Louis, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation School Teacher

11. Industry or business Public Schools

12. Name August Jean Leguay

13. Birthplace Normandy France  
(City, town, or county) (State or foreign country)

14. Maiden name Jennie Dulneau

15. Birthplace Aulun, France  
(City, town, or county) (State or foreign country)

16. (a) Informant Gus Biston

(b) Address 6434 Cecil Ave., Clayton, Mo.

17. (a) burial (b) Date thereof 3/13/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine

18. (a) Signature of funeral director Alexander Sons

(b) Address 6175 Delmar

19. (a) MAR 13 1946 (b) J. F. Bredbeck  
(Date received from registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11  
year 1946 hour 7:00 minute 40 A. M.

21. I hereby certify that I attended the deceased from 12-5-38 to 3-11-46;  
that I last saw him alive on 3-11-46;  
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy cerebral 6 hrs

Due to hypertension 15 yrs

Due to chronic arteriosclerosis 15 yrs

Other conditions optic atrophy 30 yrs  
Arteriosclerosis

Major findings: 83

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury ○

23. Signature Eugene A Vogel (M. D. or other) \_\_\_\_\_  
Address 3320 S. 6 road Date signed 3/12/46

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

9

10263

Dr E. Vogel  
3325 Lombard  
2-4 am

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....  
*Thomas R. Fenwick*

Licensed Embalmer No.....  
3793

P. O. Address.....  
St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.